WITNESS STATEMENT OF ANDREA SPITERI

Name:	**Andrea Spiteri**
Address:	50 Lonsdale Street, Melbourne, Vic, 3000
Occupation:	Executive Director of Emergency Management, Department of Health and Human Services
Date:	9 September 2020

1. I make this statement to the Board of Inquiry in response to **NTP-141**, the Notice to Produce a statement in writing (**Notice**). This statement has been prepared with the assistance of lawyers and Departmental officers.

2. This statement is true and correct to the best of my knowledge and belief. I make this statement based on matters within my knowledge and documents and records of the Department. I have also used and relied upon data and information produced or provided to me by officers within the Department.

Roles and Responsibilities

Question 1: Please describe your relevant professional experience and qualifications.

3. I received my Bachelor of Applied Science (Environmental Health) from Swinburne University of Technology in 1997. I also hold an Advanced Diploma of Public Safety (Emergency Management) from the Australian Emergency Management Institute, which I obtained in 2010.

4. I have also obtained the following qualifications or relevant workplace training:

   (a) AICD Company Directors Course;

   (b) Various Diploma of Business Accounting modules from the Central Gippsland Institute of TAFE, completed from 2000 to 2002;

   (c) PUAOPE006B Major Incident Management for Incident Controllers; and

   (d) Accredited Facilitator Emergency Management Liaison Officer Course.

5. From 1996 to November 2003, I was employed at various local government municipalities, initially as an Environmental Health Officer and then as a Team Leader Environmental Health. In these roles, I performed functions including leading and managing teams of environmental health and immunisation staff, fulfilling legislative responsibilities under various legislation and public health programs and leading the Municipal Public Health Planning committee and approach.

6. From 2003 until present, I have held a range of positions within the Department, within the areas of public health and emergency management, including:

   (a) Regional Public Health Officer (2003–2006);

   (b) Manager, Emergency Management, South Division (October 2006–2015), across Southern Metropolitan and Gippsland emergency management regions, including a 12-month secondment as Manager, Policy and Programs, Emergency Management Branch in 2012;

   (c) Acting Director, Corporate Services, South Division (March 2015–February 2016);

   (d) Area Director, Inner Gippsland (March 2016–November 2017);

   (e) Director, Emergency Management, South Division (December 2017–May 2018); and

   (f) Executive Director, Emergency Management (May 2018–present).

7. In my role as Executive Director, Emergency Management, I was appointed State Health Coordinator, in response to the COVID-19 pandemic. From 1 February to 3 July 2020, I was appointed a Class 2 State Controller, also referred to as State Controller – Health. In this role, I was involved in the state's operational emergency management governance arrangements convened in preparedness for, and operational during, this major emergency. On 7 February 2020, Jason Helps was appointed a Class 2 State Controller, known as a State Controller – Health, and we performed the role according to a rostered arrangement.

8. Since 2006, my various positions within the Department have enabled me to hold numerous emergency management roles and responsibilities in many major emergencies, including during the:

   (a) Gippsland bushfires in 2006 to 2007, as a planning officer and liaison officer;

   (b) Brookland Greens Cranbourne Methane Gas emergency in 2008, where I managed the Department's regional relief and recovery response within the Municipal Emergency Coordination Centre;

   (c) Victorian bushfires in 2009, where I managed the Department's regional response to the bushfires in the City of Casey and Cardinia Shire, support for those displaced from other areas of the State living in the region, and deployment of staff to support other affected regions over several months;

   (d) H1N1 pandemic in 2009, where I coordinated the dissemination of public health information to local governments and department programs and managed the

provision of relief services to people self-isolating, in partnership with local governments in the region;

(e) Victorian floods in 2010 to 2011, where I managed the Department's regional response;

(f) North East floods in 2012, as a planning officer within the State Emergency Management Centre;

(g) Aberfeldy fires in 2013, as the Regional Relief and Recovery Manager;

(h) Gippsland fires/Hazelwood mine fire in 2014, as the Regional Relief and Recovery Manager;

(i) Neo 200 building fire, West Footscray industrial fire, Eastern Victoria bushfires and heatwaves in 2018 to 2019, where I undertook various State Health Coordinator (**SHC**) and State agency command roles;

(j) White Island volcanic eruption in New Zealand in 2019, where I managed the state response as part of the national response under the Australian Government's Overseas Mass Casualty Plan as the SHC;

(k) Thunderstorm asthma high risk forecast events in 2019, as the Class 2 State Controller and SHC; and

(l) Eastern Victoria bushfires in 2019 to 2020, as the SHC and State Agency Commander for the Department's relief and recovery services.

9. Throughout my career, I have also held a number of governance positions, including:

(a) Committee member, Environmental Health Australia Emergency Management Special Interest Group (2001–2013);

(b) Co-Chair, Gippsland Regional Emergency Management Planning Committee (2012–2015);

(c) Deputy Chair, Regional Strategic Fire Management Planning Committee (2014–2015);

(d) Chair, Hazelwood Response Interdepartmental Committee Health and Wellbeing Working Group (2016–2017);

(e) Co-Chair, Inner Gippsland Children and Youth Area Partnership (2016–2017);

(f) Board Director, Latrobe Health Assembly (November 2017–September 2018);

(g) Chair, National Social Recovery Reference Group to the Australian and New Zealand Emergency Management Committee (May 2018–current); and

(h) Victorian emergency management representative, National Health Emergency Management Subcommittee to the Australian Health Protection Principal Committee (November 2019–current).

Question 2: What is your role within the Department of Health and Human Services (the Department) and what are you ordinarily responsible for?

10. My current role is Executive Director, leading the Emergency Management Branch of the Department. In this role I have various business as usual responsibilities relating to the roles of SHC and State Liaison Officer/Agency Commander, including multi-agency and Australian Medical Assistance Teams work and interjurisdictional deployments.

11. In my current role, my business as usual responsibilities include leading the Emergency Management Branch to fulfil key functions, including 24/7 emergency operations to coordinate health emergency responses, providing state-wide emergency relief services, including the delivery of financial assistance, and coordinating social recovery services, and identifying and managing emerging issues and areas of risk for government, the Department and the community, including through the ongoing development and management of the Department's emergency management plans, policies, procedures, and IT systems.

12. In this role, I am also a member of the executive team in the Regulation, Health Protection and Emergency Management Division, which includes the Chief Health Officer.

Question 3: What role did you play in the Hotel Quarantine Program and for what were your responsibilities in that role?

13. To understand my role and responsibilities, it might assist the Board to understand the emergency management framework which operates in Victoria. Under the *Emergency Management Act 2013*, there is an Emergency Management Commissioner who is responsible for certain coordination and control functions for emergencies. Emergencies are defined in s 3 of the Act as:

(a) Class 1, meaning a major fire, or any other major emergency for which Fire Rescue Victoria (formerly the Metropolitan Fire Brigade), the Country Fire Authority or Victoria State Emergency Service Authority is the control agency under the state emergency response plan; or

(b) Class 2, relevantly meaning a major emergency which is not a Class 1 emergency, or a warlike act or act of terrorism.

14. A major emergency means:

    (a) a large or complex emergency (however caused) which:

        (i) has the potential to cause or is causing loss of life and extensive damage to property, infrastructure or the environment; or

        (ii) has the potential to have or is having significant adverse consequences for the Victorian community or a part of the Victorian community; or

        (iii) requires the involvement of 2 or more agencies to respond to the emergency; or

    (b) a Class 1 emergency; or

    (c) a Class 2 emergency.

15. In order to discharge the responsibilities under the legislation, State responses to emergencies, including health emergencies, are guided by a number of planning documents:

    (a) *Emergency Management Manual Victoria* (**EMMV**), which sets out policy and planning documents for emergency management in Victoria, and provides details about the roles different organisations play in the emergency management arrangements;

    (b) *State Emergency Response Plan* (**SERP**), which outlines the arrangements for a coordinated response to emergencies by all agencies with a role or responsibility in emergency response;

    (c) *State Health Emergency Response Plan* (**SHERP**), a sub-plan of the SERP, used by people working in emergency services, such as paramedics, doctors, nurses and people working in public health, to help them effectively coordinate health services for the community during emergencies; and

    (d) Victorian action plan for pandemic influenza, prepared by Emergency Management Victoria to guide the pandemic preparation of each government department and agency to address the possible impacts and consequences of pandemic influenza on their organisations, and their responsibilities to communities.

16. The EMMV is available on the Emergency Management Victoria website at https://www.emv.vic.gov.au/policies/emmv. The remaining documents are available at https://www.emv.vic.gov.au/responsibilities/state-emergency-plans.

17. Victorian emergency response operational arrangements are underpinned by individual agencies performing specific tasks in response to emergencies according to their legislated role, obligations and administrative arrangements.

18. A 'control agency' is defined under the SERP as the agency with the primary responsibility for responding to a specific form of emergency.[1] The EMMV Part 7 – Emergency Management Agency Roles, lists control agencies for specific emergencies. The Department is the nominated control agency for human disease/epidemics emergencies.[2]

19. A 'support agency' is defined under the SERP as an agency that provides services, personnel or material to support the control agency.[3] A support agency is responsible for:

    (a) planning to deliver their responsibilities in accordance with the agency's legislative and administrative responsibilities, the arrangements in the SERP and in relevant SERP sub-plans;

    (b) responding to emergencies in accordance with the arrangements in the SERP or the relevant SERP sub-plans;

    (c) participating in relevant operational debriefs;

    (d) notifying the Emergency Management Commissioner of situations that may affect the capability of the agency to perform its role or responsibilities; and

    (e) paying the costs of the emergency response that are the responsibility of the support agency, as outlined in the EMMV Part 8 Appendix 1, except where other specific cost sharing or cost recovery arrangements are in place.[4]

20. A support agency commander is responsible for:

    (a) supporting the directions of the controller at that tier;

    (b) establishing an agency or functional command structure to suit the circumstances;

    (c) taking charge and provide leadership of agency or functional resources ensuring they are focused on supporting the controller to resolve the incident;

    (d) participating in and contribute to team meetings at the respective tier, as required

    (e) ensuring the timely flow of information, at the relevant tier, to the controller, emergency response coordinator, recovery coordinator / manager; and

    (f) work within the control structure for the emergency.

[1] EMMV Part 3, 'Definitions'.
[2] EMMV Part 7, Agency Role Statements, 'Department of Health and Human Services'.
[3] EMMV Part 3, 'Definitions'.
[4] EMMV Part 3, Appendix A – Role Statements, Agencies: support agency.

21. The EMMV distinguishes between:

    (a) coordination (bringing together agencies and resources to ensure effective response to and recovery from emergencies);

    (b) control (the overall direction of response activities in an emergency, operating horizontally across agencies); and

    (c) command (the internal direction of personnel and resources, operating vertically within an agency).[5]

22. The significance of this is with respect to the organisational structure I describe below. Although the Agency Commanders of support agencies in accordance with their emergency management roles and responsibilities reported to me in relation to their COVID-19 support activities undertaken, neither I, as State Controller – Health, nor the Department, as control agency, had command of a support agency or its response activities, or could exercise a support agency's contractual or legislative obligations.

23. The officer in charge of an agency having overall control of response activities in relation to a Class 2 emergency may appoint one or more controllers for planning for anticipated Class 2 emergencies or a Class 2 emergency which is occurring or has occurred.[6]

24. On 1 November 2019, I was appointed as a Class 2 Controller (known as State Controller) under the SERP and SHERP by Kym Peake, Secretary of the Department. The appointment was for one year, which enabled the timely appointment of Class 2 Controller for a specific Class 2 emergency when required.

25. At the commencement of the novel coronavirus emergency, I was the SHC, and was first briefed by Dr Angie Bone on 24 January 2020 about the first case in Victoria. The planning and response to the novel coronavirus was led by the Department's Health Protection team. This occurred at the same time as the continuing response to the 2019-20 Eastern Victorian bushfires. Concurrent with that ongoing response, I began to contribute to Departmental planning, led by the Health Protection team, for the health coordination and other Departmental emergency management functions. During this time, I contributed information about the novel coronavirus emergency during my representation of the Department in the State Control Team.

26. On 1 February 2020, I was appointed as a Class 2 State Controller for the 2019 novel Coronavirus emergency by Kym Peake, Secretary to the Department, on the recommendation

[5] EMMV 3.2.1 Overview.

[6] *Emergency Management Act 2013* s 39(2); EMMV 3.3.2, Appendix B 'Class 2 emergencies'.

of Melissa Skilbeck, the Deputy Secretary. This appointment was made pursuant to the instrument of appointment issued 1 November 2019, which I refer to at paragraph 24 above, and available at DHS.5000.0060.9489.

27. This was the first appointment of a State Controller (which became known as the State Controller – Health to distinguish it from other State Controllers) for a class 2 human disease pandemic in Victoria, with a remit to coordinate whole of Victorian Government planning and responses to the broader impacts and consequences of the pandemic.

28. The SERP states that State Controller's specific responsibilities are to:

(a) lead and manage the response to a Class 2 emergency;

(b) establish a control structure for the Class 2 emergency as appropriate and monitor to ensure it suits the circumstances;

(c) issue warnings and information to the community in relation to the Class 2 emergency, if regional or incident tier controllers are unable to do so in a timely manner;

(d) support the Emergency Management Commissioner to identify current and emerging risks, or threats in regard to the Class 2 emergency and implement proactive response strategies;

(e) support the Emergency Management Commissioner in the development of state strategic plan for managing the Class 2 emergency;

(f) give directions to regional and/or incident controllers if applicable;

(g) work with the Emergency Management Commissioner to lead the State Control Team (**SCT**) (or work with the other state tier controllers, if appointed);

(h) participate in the State Emergency Management Team (**SEMT**);

(i) oversee the operational functioning of the State Control Centre or other facility from where the emergency is being managed, in relation to the Class 2 emergency;

(j) ensure the timely flow of relevant information to the:

(i) Emergency Management Commissioner;

(ii) SCOT (State Coordination Team);

(iii) SCT;

(iv) SEMT;

(v) other support teams and stakeholder agencies; and

(k) apply the Emergency Management Commissioner operational standards and incident management procedures, as appropriate.[7]

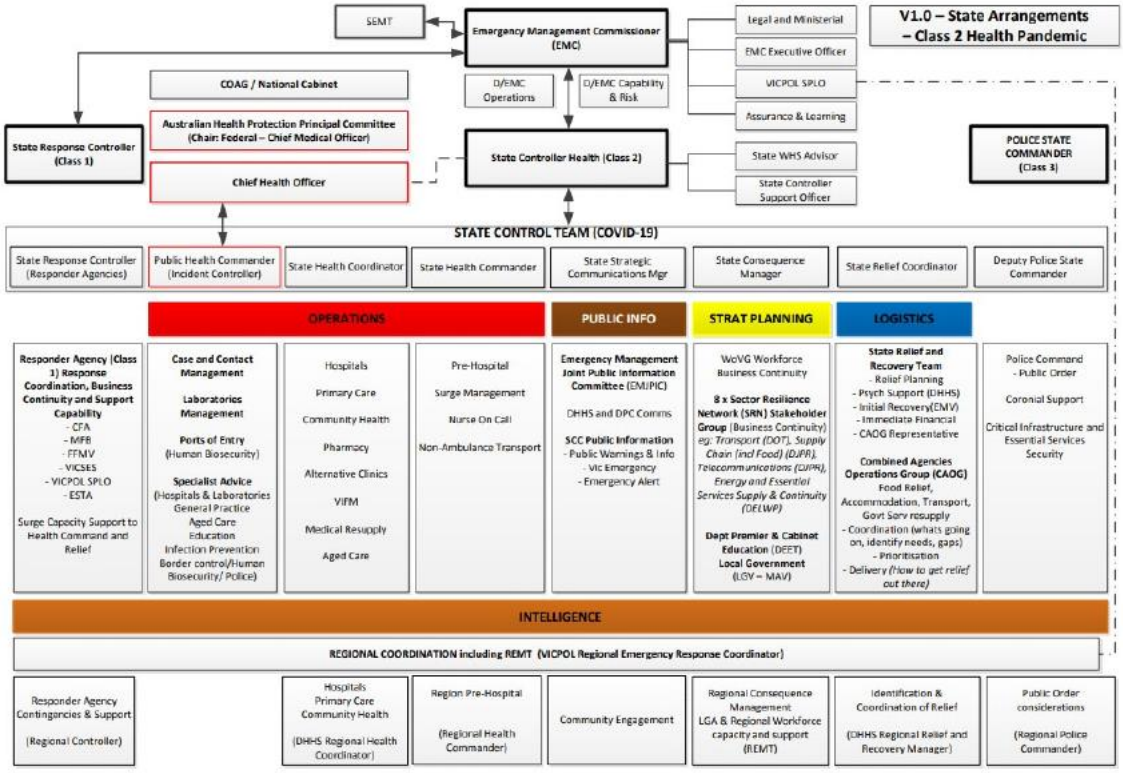
29. As State Controller – Health, I recognised that from the start of the novel Coronavirus emergency (later declared the COVID-19 pandemic by the World Health Organisation) the effects and consequences of the COVID-19 pandemic had the potential to exceed the effects and consequences of any other emergency in Victoria's recent history of emergencies. The potential and actual numbers of deaths and illness, the potential for significant effects over a long period on the health and lives of Victorians (as seen in other countries), and on critical infrastructure including the health system, and the far-reaching social and economic effects, all meant that governments needed to be and were the decisions makers for strategies to minimise, control and respond to these effects and consequences.

30. Practically, the Chief Health Officer was an incident controller, operating across the state, with the powers under the *Public Health and Wellbeing Act 2008* to make directions to mitigate and control the spread of the virus.

31. This meant the role of the State Controller – Health role for this Class 2 emergency became one of overall coordination of the implementation of both Chief Health Officer and government decisions and directions across government and agencies, through the operational arrangements for COVID-19, utilising the structures and resources of the State Control Centre. This coordination role was well understood by those responsible for emergency management in Victoria.

32. The State control arrangements were subsequently set out in the State Strategic Operations Plan, updated for 30 March 2020 to 12 April 2020, available at DHS.5000.0131.5853. Appendix 1 showed the State control arrangements, in contrast to the Operation Soteria control arrangements, as:

[7] EMMV, Part 3, Appendix A - Role Statements, Controllers: Class 2 State Controller.



33. There were four versions of the Operation Soteria operations plans implemented to manage mandatory hotel quarantine for all passengers arriving in Australia after midnight on Saturday 28 March 2020:

    (a) Operation Soteria Plan (v1.0) dated 28 March 2020 (available at DHS.0001.0001.1475);

    (b) Operation Soteria Plan (v2.0) dated 26 April 2020 (available at DHS.5000.0079.0864);

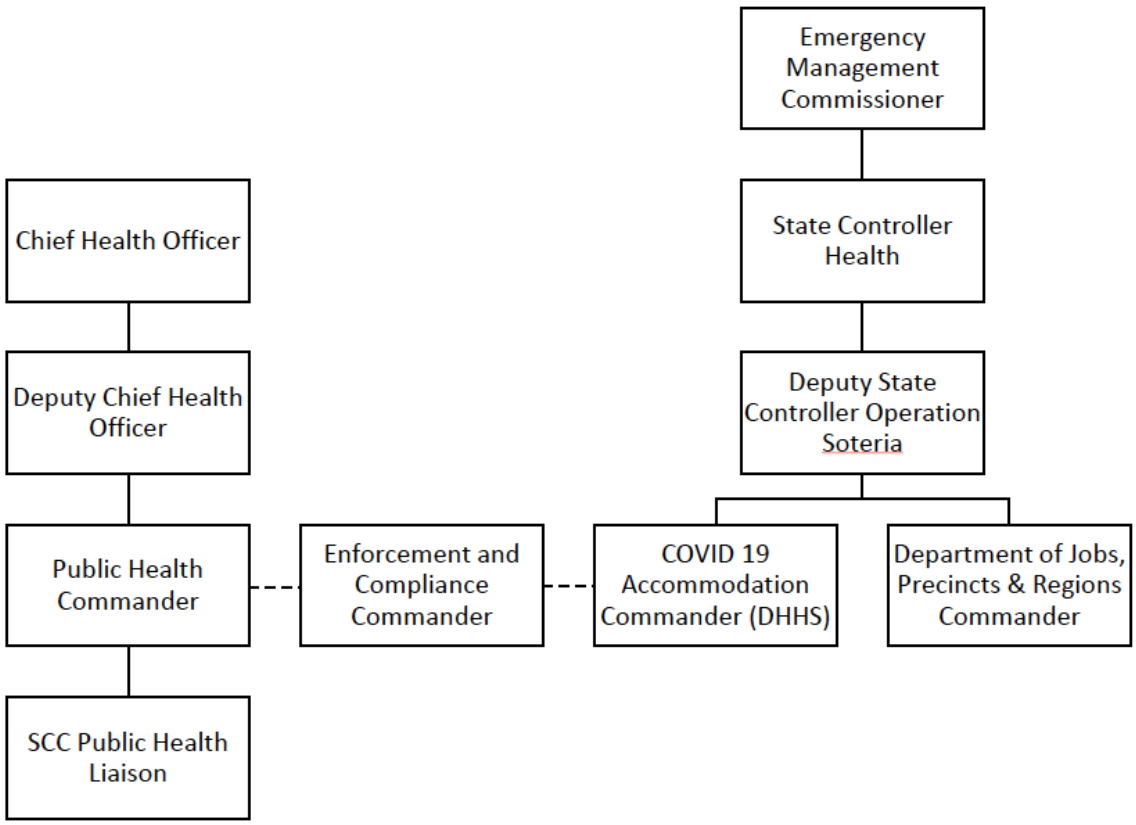
    (c) Operation Soteria plan (v2.1) dated 8 May 2020 (available at DHS.0001.0008.0517); and

    (d) Operation Soteria Plan (v3.0) dated 26 May 2020 (available at DHS.0001.0001.1053).

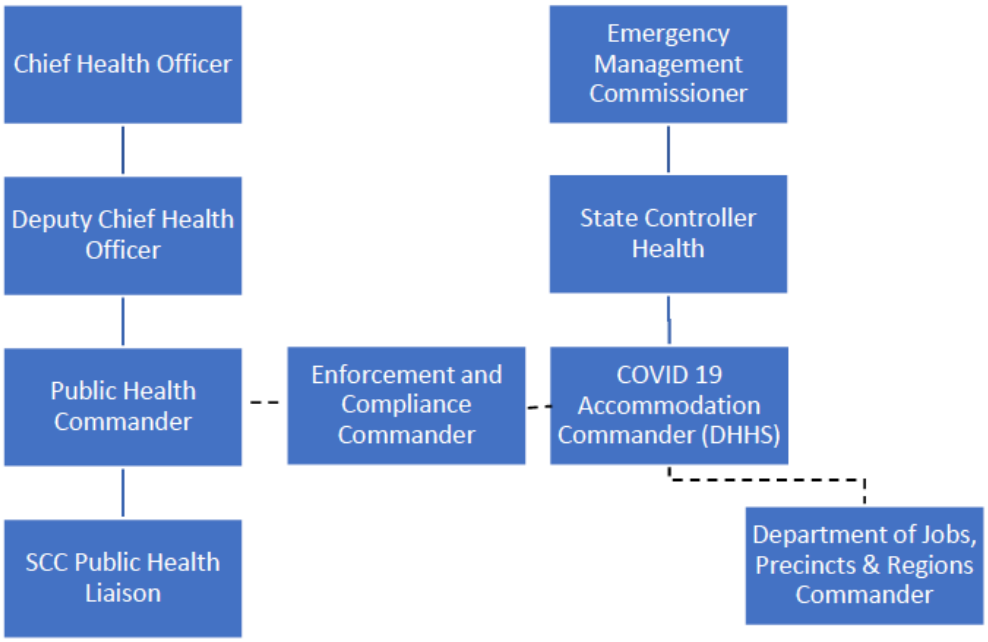
34. Version 1 of the Operations Plan did not describe an organisational structure.

35. There were slight variations over time, but in general, the State Controller — Health reported to the Emergency Management Commissioner, and the Department's COVID-19 Accommodation Commander reported to the State Controller – Health or Deputy State Controller — Operation Soteria. The following diagrams set out the reporting.

36. The organisational structure in v 2.0 was:



37. The organisational structure in v 2.1 was:



38. In accordance with the Operation Soteria Operations Plan, section 2.1, I was responsible:

    (a) for the oversight and coordination for the Hotel Quarantine Program accommodation operations; and

    (b) to give effect to the decisions and directions of the Public Health Commander and Enforcement and Compliance Commander, through the Deputy State Controller – Operation Soteria, and then the COVID-19 Accommodation Commander.

39. At its simplest, as State Controller – Health, I had operational accountability for the quarantine accommodation of returned travellers.

40. The effect of this is that I was responsible for ensuring that:

    (a) an appropriate operations plan was in place for the Program, with roles and responsibilities allocated; and

    (b) appropriate governance arrangements were in place for the Program operations and logistics, for escalation and resolution of issues, and resourcing support through the State Control Centre.

41. Public Health functions in the Hotel Quarantine Program were the responsibility of the Chief Health Officer, Deputy Chief Health Officer and Public Health Commander. The Enforcement and Compliance Commander also fell under Public Health.

42. Health and welfare policies, processes and standards were a responsibility of the Public Health Commander, and initially, the Department's agency commander in the State Control Centre was responsible for health coordination operations and logistics, namely:

    (a) sourcing General Practitioners in hotels;

    (b) allocating nurses to hotels;

    (c) initial arrangements for mental health triage; and

    (d) access to pharmacy (24/7) and pathology services.

43. Initially the welfare cell and functions sat under the Public Health Commander.

44. The hotel quarantine health coordination function and the welfare cell began to transition to sit under COVID-19 Accommodation Commander on or about 17 April 2020, to connect with the hotel operations. This decision followed an initial meeting with the Department's Commanders with responsibilities for hotel quarantine functions and myself as State Controller – Health, chaired by Euan Wallace, on 14 April 2020. I was keen to bring together

the Department's various plans and procedures we had or were developing for the Hotel Quarantine Program under the Operation Soteria Operations Plan. This was the genesis of what became the Annexes to the Operation Soteria Operations Plan, specifically:

(a) Annex 1 COVID-19 Compliance Policy and Procedures - Detention Authorisation (v1) dated 29 April 2020 (available at DHS.5000.0025.4759);

(b) Annex 1 COVID-19 Compliance Policy and Procedures - Detention Authorisation (v2) dated 24 May 2020 (available at DHS.0001.0013.0006);

(c) Annex 1 COVID-19 Detention Compliance and Enforcement (v2.0) dated 1 June 2020 (available at DHS.0001.0105.0001);

(d) Annex 2 – Health and Wellbeing (v2.0) dated 1 June 2020 (available at DHS.0001.0106.0001); and

(e) Annex 3 – COVID-19 Operational guidelines for mandatory quarantine (v2.0) dated 1 June 2020 (available at DHS.0001.0105.0029).

Health and wellbeing of people in quarantine

Question 4: What measures were in place to manage the healthcare and wellbeing of people in quarantine? If your answer differs for different time periods, or for different locations, please specify.

45. My first shift on roster as State Controller – Health following the announcement and establishment of the Hotel Quarantine Program was on 30 March 2020.

46. Overall, the healthcare put in place in hotels was a primary care model, with general practitioners and nurses on site at each hotel, and escalation/referral options to health services (hospitals) where required. Guests were encouraged to arrange contact and attend telehealth consultations with their usual practitioner if available.

47. I understand that an existing contract with Your Nursing Agency was used to source nurses and initially Field Emergency Medical Officers were activated in accordance with the SHERP to provide a medical practitioner onsite at hotels, with arrangements for Ambulance Victoria to transport returned travellers to hospital if required.

48. Initial social wellbeing measures included the provision of a contact number to access advice and referrals from social workers, and connection to the Mental Health triage team for the area.

49. The Department also put arrangements in place to access pharmacies 24/7, for twice daily pathology services and the establishment of a Beyond Blue hotline for all quarantine hotels.

50. Hotel quarantine is an alternative to home quarantine, not hospital care. The underlying assumption is that any returning traveller could be, or become, COVID-19 positive at any stage during their quarantine period, and any returning traveller who was assessed as needing hospital care during their quarantine period was transported to hospital.

51. At no time did the Department have details of any health or other needs of returned travellers before their arrival, therefore it could not tailor healthcare and wellbeing measures to meet specific requirements of passengers prior to their reception into Victoria.

52. The initial healthcare and wellbeing measures put in place in the first hours and days of the Hotel Quarantine Program were a standard base-level of healthcare and wellbeing support put in place at short notice. The Department used pre-existing arrangements under the SHERP, and a contract the Department already had in place for nurses. These arrangements were similar to those that had been activated for large relief centres during other types of emergencies where emergency-affected people's needs were not known prior to their arrival.

53. As it became clearer that the Hotel Quarantine Program would be required for a longer period, General Practitioners were sourced to service the hotels to replace Field Emergency Medical Officers, who had substantive roles in health services and General Practice, and mental health nurses were sourced and rostered to each hotel to support passengers directly and link to the existing mental health triage service for any acute mental health issues.

54. Healthcare and wellbeing measures operationalised for all quarantine hotels were originally documented in the Operation Soteria Health and Wellbeing Arrangements, which was reviewed by Safer Care Victoria on 12 April 2020 (available at DHS.0001.0104.0001).

55. A system was established to contact daily each returned traveller to check on their health and welfare, as well as meet the daily review requirement under the *Public Health and Wellbeing Act 2008*. This was initially undertaken remotely via a call centre, and then by nurses in each hotel, who could address issues on site and if required escalate to the General Practitioner, or department staff where required. To ensure efficacy and to manage infection prevention and control risks, this was done via telephone.

Question 5: In your view, were those measures adequate and appropriate? Why or why not?

56. Yes, in my view, the measures in place were adequate and appropriate.

57. The Department sought to promote the health and wellbeing of people in hotel quarantine and support people with their health and welfare needs to enable them to remain in quarantine, so

as to mitigate the public health risk posed by their potential COVID-19 infection, whilst also balancing requirements under the Charter of Human Rights and Responsibilities.

58. The healthcare and wellbeing arrangements continued to evolve throughout the Hotel Quarantine Program due to changes in the demographic of returning travellers and the Department's experience in running the Hotel Quarantine Program. After the first few weeks, the returning traveller cohort changed, and the complexity of health and wellbeing issues increased. The number of older people and large families increased during this time, often with an unexpected number of infants, and many returning travellers had significant health and social issues. Returned travellers were often expats or had not a lot of experience living in Australia, and some did not have pre-arranged accommodation to go to post hotel quarantine.

59. While the Department's knowledge and experience in providing the Hotel Quarantine Program expanded, and healthcare and welfare arrangements were refined, a significant challenge remained in that at no time during the Hotel Quarantine Program did the Department have details of individuals prior to their reception in Victoria. The Department only had an estimate of total numbers of adults and children provided before travellers landed at the airport.

60. There was a high level of cooperation between all healthcare and welfare providers involved in the Hotel Quarantine Program. All involved in the Hotel Quarantine Program needed to work with a high level of adaptability, and a high degree of collegiality was evident. Everyone was learning as they worked, and the ability to draw on expertise from Departmental staff with previous health and human services backgrounds and experiences, and health and welfare professionals such as Ambulance Victoria staff, Field Emergency Medical Officers, nursing staff and complex case workers, was vital to the provision of high quality healthcare and support for the welfare of quarantined travellers.

Question 6: How were decisions made, and what factors were taken into account, when determining which detainees (or groups of detainees) could be placed in locations with, or separated from others?

61. This did not form part of my role and responsibilities as State Controller – Health.

62. I understand that the Department of Jobs, Precincts and Regions (**DJPR**) received the passenger manifests and determined the allocations of returned travellers to hotels. I understand that any information that was available, such as number of children and families, was used by DJPR staff to allocate returning travellers to the most appropriate hotel accommodation as much as possible, subject to availability within the contracted hotels.

63. I understand Department staff in the State Control Centre and then in the Emergency Operations Centre worked with DJPR so that health and welfare considerations informed

sourcing of appropriate accommodation options for different cohorts of returning passengers as much as possible.

Rydges Carlton as a "hot hotel"

Question 7: Who decided that there would be a "hot hotel" and who decided that it would be the Rydges Hotel on Swanston St in Carlton (Rydges Carlton)?

64. I am not familiar with the phrase "hot hotel" but take it to mean a hotel to accommodate only COVID-19 positive cases. The terminology I used during my involvement with the Hotel Quarantine Program was "COVID-19 positive hotel".

65. Originally COVID-19 positive returned travellers were moved to and accommodated on "red floors" within the hotel in which they were staying. A red floor was a designated floor within a quarantine hotel where only COVID-19 positive returned travellers were accommodated.

66. On the evening of 31 March 2020, the Department was alerted to a community member with COVID-19 who was homeless and who required relief accommodation. To that point, the Department had been unable to source a hotel to accommodate people from the community who were positive for COVID-19. We contacted first a Departmental hotel team leader and then I called Claire Febey to request access to a quarantine hotel red floor to accommodate the person. I was advised that this was beyond the scope of the current contracts and the hotels refused the request.

67. On 1 April 2020, the Department worked further with DJPR who subsequently advised that the Rydges Carlton would be stood up as a COVID positive hotel from 2 April 2020. I do not know who decided Rydges Carlton would be the best option to be designated the COVID-19 positive hotel.

68. On 2 April 2020, I was copied into an email from Claire Febey regarding the Rydges Carlton (available at DHS.5000.0001.1240). In her email, Claire stated that Rydges Carlton had been "*activated"* to take confirmed COVID-19 cases as from the evening of 2 April 2020. The email confirmed that the hotel was set up to receive confirmed cases from the general community that were expected to comply with their isolation.

69. Subsequently, work was undertaken to consider the use of a COVID-19 positive hotel to transfer all COVID-19 positive cases from other quarantine hotels. This was endorsed by the Public Health Commander on 7 April 2020. I understand the first use of Rydges Carlton was from 12 April 2020 to accommodate passengers returning from Uruguay who had been on the Greg Mortimer ship, the majority of whom were or had been COVID-19 positive. From around the 29 April 2020, after the Greg Mortimer passengers had exited their quarantine in the Rydges Carlton, the COVID-19 Accommodation Commander advised that all people who

tested positive for COVID-19 in hotel quarantine would be moved to Rydges Carlton to complete their quarantine period.

Question 8: What was the rationale for creating a "hot hotel"?

70. Originally, I personally requested the establishment of a COVID positive hotel as a relief accommodation option for people in the community who were COVID-19 positive and who needed alternative accommodation in which to safely self-isolate. I indicated to Claire Febey on the evening of 31 March 2020 that the Department needed this option, and on 1 April 2020 met with DJPR and Department representatives to discuss what would be needed to stand up this accommodation. During this meeting, DJPR advised that Rydges Carlton could be an option. DJPR would negotiate with the hotel, and advise the Department regarding potential to stand up the following day.

71. It was recognised at that stage that for some members of the community (due to their living arrangements), isolating at home created a greater risk of community transmission or transmission to others in their household (who had a higher risk of complications if infected – for example, elderly family members or immune compromised persons).

72. The rationale for the establishment of that hotel was therefore that the risk of infecting others or increasing community transmission could be reduced by providing relief accommodation in which an infected person could isolate.

73. On 7 April 2020, the Public Health Commander endorsed via email an approach to provide a dedicated COVID-19 positive hotel to accommodate returning travellers who tested positive to COVID-19, as this approach reduces the low (but material) risk that as a result of detaining well individuals in a hotel they could acquire COVID-19 from the hotel environment (available at DHS.5000.0131.0555).

74. By moving all COVID-19 positive returned travellers to a single COVID-19 positive hotel, the need to establish a "red floor" at each hotel (for a relatively small number of COVID-19 positive travellers), was avoided. As noted in Operation Soteria meeting minutes dated 27 April 2020 (available at DHS.0001.0005.0246), the implementation of a COVID-19 positive hotel created additional capacity at the non-COVID-19 positive hotels.

Question 9: What (if any) additional infection control measures were implemented when it was decided to use the Rydges Carlton as a "hot hotel"? Please provide details, including relevant documents.

75. I understand that additional infection control measures implemented at the Rydges Carlton were as follows:

(a) transporting returned travellers via Maxi Taxi from the airport/other hotel to the Rydges Carlton in a manner that maximised social distancing;

(b) instructing taxi drivers to wear appropriate Personal Protective Equipment (**PPE**) (masks and gloves) when driving returned travellers to the Rydges Carlton;

(c) the Department Team Leader of the exiting hotel site advising the Department team leader at Rydges Carlton at the time of the returned traveller's departure, to ensure that a nurse and security guard (wearing appropriate PPE) were able to meet the taxi on arrival;

(d) the Department Team Leader of the exiting hotel advising Department staff in Operation Soteria of the relocation;

(e) escorting the newly arrived returned travellers straight to their room upon arrival at the Rydges Carlton;

(f) implementing a contactless system to obtain information from arriving passengers so that no paperwork was exchanged between passengers and nurses. Practices regarding movement of luggage were also updated so that luggage was cleaned and bagged before being moved;

(g) ensuring COVID-19 positive community members accommodated at the hotel understood they were required to speak to Department staff on site if there was a need for them to leave their rooms;

(h) requiring all guests to wear masks when they were outside their rooms.

76. I understand that infection prevention and control experts were involved in the initial set up and opening of Rydges Carlton, and on 14 April 2020, the Department contracted Infection Prevention Australia to provide advice and on-site guidance on infection prevention and control at Rydges Carlton.

Question 10: In your opinion, were the infection control measures at the Rydges Carlton when it as a designated 'hot hotel':

(a) appropriate?

77. In my opinion, the infection control measures in place at the Rydges Carlton when it was a designated "hot hotel" were appropriate.

(b) adequate?

78. In my opinion, the infection control measures in place at the Rydges Carlton when it was a designated "hot hotel" were adequate.

Why? Why not?

79. I consider that the infection control measures at the Rydges Carlton were appropriate and adequate because of the steps taken from early on in the establishment of the program which I detail below. I do acknowledge, however, that there were transmission events. Transmission events have been seen in a variety of settings including in programs in other jurisdictions and in healthcare settings with staff who have years of training and knowledge in infection control.

80. I understand that the Department's public health advice on infection prevention and control measures was based on information about the virus that was available to it at the particular time. I observed that updated guidance was frequently given to health service providers by the Department's Public Health team as new studies and literature was released.

81. Information and guidance on infection prevention and control measures, such as recommended type and use of PPE, hand hygiene practice, physical distancing measures, the requirement not to attend work when sick, processes for movement of guests, luggage, and cleaning guidance for hotels was available at hotels, and to all Victorians on the Department's website and through other communication strategies, including VicEmergency state-wide Advice – Pandemic messages. This information was constantly updated to reflect the latest knowledge of the virus, and if followed, I understand that accepted medical opinion is that the recommended measures minimised the risk of infection.

82. As referred to above, expert infection prevention consultants were also contracted to assist with the Rydges Hotel. Infection Prevention Australia personnel worked with the Department at Rydges Carlton in the lead up to its opening as a COVID positive hotel, and then returned to the premises a number of times to check that the relevant procedures were in place and followed, including meeting with security staff on site on multiple occasions to train them. I understand a number of training sessions were specifically provided to new security staff when the security contract changed after 11 May 2020. Knowledge was also reinforced by signs in use at the hotel to remind staff of infection prevention and control measures. Written instructions were also available on site. The provision of PPE at the Rydges was thorough and I do not believe there was any suggestion that there were issues with supply of PPE at the Rydges Carlton.

83. I understand an audit of infection prevention and control at Rydges Carlton was undertaken by Infection Prevention Australia, and the report provided to the department on 4 May 2020.

84. As previously stated, the Hotel Quarantine Program provided an alternative to home quarantine for individuals who did not require hospital treatment. It was therefore not considered that those accommodated at Rydges Carlton were in a hospital-like environment. Clear arrangements were in place for those needing hospital care to receive this care in appropriate hospitals.

Question 11: Why was there a subsequent decision to involve Alfred Health in the management of 'hot hotels' in the Hotel Quarantine Program?

85. The Department had recognised that the engagement of an existing health service with expertise and experience in health care, testing, movement of infectious people, cleaning and security was desirable for the Hotel Quarantine Program in the longer term. Accordingly, Alfred Health was approached to provide assistance as it allowed the program the advantage of harnessing an already trained and experienced workforce rather than creating a new one.

86. Initially all Victorian health services were focussed on managing the anticipated increased demand for intensive care because of the then projected significant increasing of COVID-19 cases in Victoria and across Australia. However, as the Program developed and the anticipated surge in hospital admission did not occur, increased involvement of the health care sector was able to be considered.

87. Alfred Health was already connected with the Hotel Quarantine Program as Alfred Health nurses had been working in hotels from mid-April to support the completion of daily health checks for all guests.

88. I understand a meeting was held between the Department and Alfred Health on 29 May 2020. During this meeting, the management requirements for the COVID-19 positive hotel were discussed, and the first proposal from Alfred Health was received the following week. The contract commenced with the opening of Brady Hotel on or around 17 June 2020.

End of detention

Question 12: What was the policy for when people were permitted to exit quarantine? If a different policy applied at different times, or in different locations, please specify.

Please provide any relevant documents.

89. I was not involved in decisions about exit policies, as this was not part of my role as State Controller – Health. I understand exit policies were developed and implemented by the Enforcement and Compliance Commander in accordance with public health directions and guidance. This was because on exit they were treated the same as any other person in the community in their circumstances, whether they had been COVID-19 positive, a close contact or negative for COVID-19.

90. The Department's COVID-19 Accommodation Commander oversaw the process for the first exits of returned passengers in the hotel quarantine program, working with DJPR, who managed the logistics of the exit process with travellers, including transport, and the Department's Enforcement and Compliance team, who were required to provide each passenger with a release notice.

Reservations and reflections

Question 13: Did you, at any time, have any reservations about any aspect of the Hotel Quarantine Program? If so, what were those reservations and to whom did you convey them? What was their response?

91. The Hotel Quarantine Program was established under Victoria's emergency management arrangements to enable the urgent allocation of roles and responsibilities to agencies to support the Department as the control agency. This was in accordance with the Emergency Management Manual of Victoria, and the Chief Health Officer exercising authority under the *Public Health and Wellbeing Act 2008* as the legal framework for the program. On 30 March 2020, I concluded that a dedicated executive officer was required to lead the Department's COVID-19 Accommodation operations. I conveyed this to the Deputy Secretary of the Department, and a dedicated COVID-19 Accommodation Commander role commenced on 3 April 2020.

92. The Department's Agency Commander and emergency management staff continued to undertake the Department's accommodation operations in the State Control Centre until the program fully transitioned under the COVID-19 Accommodation Commander to an Emergency Operations Centre in the Department's Fitzroy office on 17 April 2020, and commenced a dedicated structure.

93. In addition, it was clear to me that the Program's governance and administration needed to transition from an emergency management response to enable appropriate and sustainable longer term clinical and operational governance of the Hotel Quarantine Program under one department or agency management structure, including all contractual arrangements. I discussed with the Emergency Management Commissioner and the Deputy Secretary the need to transition from the emergency management arrangements to a program approach, and both agreed that Operation Soteria needed to transition to a longer term and sustainable program, with resourcing and contracting to be under the Department. Through discussion with DJPR, the timing of this was agreed to be from 30 June 2020.

94. Early in the establishment of the Hotel Quarantine Program I held reservations about the lack of communication and sharing of information between DJPR and the Department. In my view, this was affecting the ability of the Department to contribute with regards to the assessment

and suitability of contracted hotels, and the rostering of sufficient staff at hotels. Department staff escalated this issue to me and I conveyed this to the Department's Secretary via email on 6 April 2020 (available at DHS.0001.0104.0005). In response, the Secretary advised me she would contact the Secretary to DJPR and raise our concerns with him. Following this, I believe that the communication and information flow as between the Department and DJPR did improve.

95. During my involvement with the Program, I held reservations about the lack of available resources to sustain the Hotel Quarantine Program, especially if the number of returning passengers were to increase. I was of the view that there was a considerable risk of staff burnout, especially as other COVID-19 response activities increased. I discussed this issue with DJPR executives and the Department's Deputy Secretary on multiple occasions. I believe that the Deputy Secretary was cognisant of the significant resourcing challenges and was working within the Department and across government to resolve. The transition of the Program from an emergency management model to a department or agency led model with dedicated recruitment was planned and would also have addressed this.

Question 14: Did you have any views as to the role(s) that should be played by:

(a) Victoria Police; and

(b) Australian Defence force personnel,

in relation to the Hotel Quarantine Program? If so, what were those views, and to whom were they expressed?

Victoria Police

96. I believe that Victoria Police played an integral role in the planning and implementation of the Hotel Quarantine Program, in accordance with their roles and responsibilities outlined in the various Operation Soteria Operations Plans. Victoria Police actively participated in the Hotel Quarantine Program from the initial planning and stand up of hotels, in Operation Soteria interagency meetings, bringing issues as they arose for discussion and resolution, at each hotel site during walk throughs and during operation of the hotels. The Senior Police Liaison Officer was a member of the State Control Team and I had regular discussions with him in relation to the Hotel Quarantine Program. In addition, the Department took the proactive step of deploying an Emergency Management Liaison Officer into the State Police Operations Centre to facilitate connection between the Department and Victoria Police's enforcement functions, which in my view was beneficial.

97. An example of the collaborative relationship between the Department, other agencies and Victoria Police includes an instance when I was contacted by the Senior Police Liaison Officer

and the Assistant Commissioner, State Emergencies and Support Command on 14 April 2020 about fresh air breaks at a city hotel where guests needed to be escorted into public areas due to lack of alternative options within the hotel. Victoria Police requested a forum with security companies to discuss security practices, which was agreed. The forum was held on 16 June 2020, and attended by various staff from the Department, Victoria Police, DJPR and representatives of all security companies contracted to provide services at quarantine hotels. I saw this as a proactive approach to ensure security practices were undertaken within the appropriate private security legal framework, and appreciated the ongoing advice and guidance provided by Victoria Police in the Hotel Quarantine Program, including to the private security companies.

98. As far as possible, the Department took a health and welfare approach to the Hotel Quarantine Program, to ensure people were supported and secure, particularly those with pre-existing health, mental health and social issues. The Department was conscious of the need to balance security and support services for returned travellers who were overwhelmingly cooperative and compliant.

99. My personal view is that it would have been preferable to have a small Victoria Police presence at every hotel 24/7 in addition to private security, but not to replace private security entirely. I believe the Department's staff would have felt safer in the hotels if this had been in place, and in turn, returned travellers would not feel intimidated or alarmed by a full Victoria Police presence on every floor. A small constant police presence would take into consideration any fears or concerns that cohorts of returned travellers (including children) might have to a heavy police or uniformed presence, particularly as a result of any previous experience of trauma or war, and yet provide an added perception of safety for staff.

100. I expressed the view about staff safety verbally to the Enforcement and Compliance Commander and the Department's Agency Commander on 10 April 2020. Decisions about Victoria Police's role in the Hotel Quarantine Program had been made by others early in the Program, and Victoria Police continued to advise that it would not provide a 24/7 presence at all hotels as this was not required. I believe that this position was understandable given that a risk of absconding from quarantine hotels had not materialised and the requirement for police attendance to incidents was low.

101. I understand that an escalation process was put in place, and that process worked well for emergency situations where Victoria Police was required at hotels. I also understood escalation of security-related issues (non-emergency situations) was to be made to the DJPR site manager for each hotel, and that this was the preference of DJPR. That was noted in an email from the COVID-19 Accommodation Commander in relation to the escalation of an issue at the Stamford Hotel, which I received on 16 June 2020 (available at DHS.0001.0013.1302).

102. Upon reflection of the Program, it is also my personal view that a 24/7 police presence at quarantine hotels may have been helpful in setting an example for security staff as to appropriate behaviour, or potentially acting as a deterrent for inappropriate behaviour, and providing support to the Department's onsite staff in their roles. I recollect expressing this view verbally on several occasions to other Departmental executive staff, however, it is my personal opinion as opposed to an evidence based view that could have been justified at the time of setting up the program or engaging with issues around an increase in police presence.

The Australia Defence Force

103. From about 27 March 2020 Australian Defence Force (**ADF**) personnel directly supported the Hotel Quarantine Program in planning roles for several months. I understand the ADF assisted in drafting the Operation Soteria Operations Plan v1.0 approved 28 March 2020 (available at DHS.0001.0001.1475), and continued to support the operation working in the Public Health Incident Management Team, in the State Control Centre and in the Department's Emergency Operations Centre planning team.

104. It is my understanding that ADF resources can be requested by the State of Victoria for tasks where the requirements cannot be met by the State's existing resources (including all government, community or commercial options), in accordance with Guiding Principles in the Australian Government Disaster Response Plan COMDISPLAN 2017. Further, the ADF cannot lead an operation within the State, and must at all times report to a staff member of the requesting agency at any work location to which it is deployed.

105. A copy of the Australian Government's COMDISPLAN 2017 is publicly available at https://www.homeaffairs.gov.au/emergency/files/plan-disaster-response.pdf

106. In other words, Victoria, along with all other States and Territories must exhaust local resources before ADF assistance can be formally requested. In accordance with Section 2 of COMDISPLAN 2017, the nominated officials in Victoria who have authority to make a request for ADF assistance are the Emergency Management Commissioner (Victoria), and the Chief Commissioner of Victoria Police.

107. Decisions on the role of the ADF in the Hotel Quarantine Program had been made by others early in the initial planning of the Program, and I did not consider it was within my authority as State Controller - Health to change those decisions.

108. As part of discussions about potential options to replace private security in quarantine hotels in late June 2020, we looked into a potential expansion of the role of ADF in supporting the Program, along with other options. My personal view was that, while ADF resources could be utilised in the Program, this would not be a long term or sustainable option, and at best could be an interim option for a few weeks to allow for planning and implementation of a state-based

option, such as increasing the use of Victoria Police and Protective Services Officers in hotels. I expressed this view to the Deputy Secretary and Emergency Management Commissioner.

Question 15: What, if anything, do you consider that:

(a) the Department;

(b) other government departments or private organisations;

(c) you,

should have done differently, in relation to the Hotel Quarantine Program?

The Department

109. Earlier strengthening of the role and rostering of the Department's team leaders in hotels, as well as clearer communication about the roles of the Department's team leaders, Authorised Officers, and DJPR site managers would have assisted all staff working in the quarantine hotels to understand who to report to for issues escalation and resolution. A clear, consistent and communicated unified command structure at each hotel, with consistent staffing of key management positions could have ensured all staff working in quarantine hotels knew who was in charge of which aspects of the operation. The ongoing challenge to resource Departmental Team Leader and Authorised Officer roles, given the speed with which the program was initially stood up and then the pace of standing up new quarantine hotels, was a key factor in preventing this from occurring.

Other government departments or private organisations

110. Given the early confusion and time spent on clarifying roles and responsibilities under the emergency management arrangements, earlier direct engagement with the State Controller – Health by all government departments or agencies tasked upon decision and announcement of the program would have been ideal.

111. Earlier engagement of the Department in the initial contracting of hotels would have prevented contracting of hotels in areas where hotels were not able to be used for mandatory quarantine, such as in regional settings, and enabled a better understanding of the legal framework for mandatory quarantine, and required infection prevention and control measures, and how this needed to be operationalised in hotels to inform hotel selection.

112. All organisations providing staff to work in hotel quarantine needed to take responsibility to ensure their staff understood and complied with all infection prevention and control measures in place at the hotels. In addition, individual staff working in the Hotel Quarantine Program needed to each comply with all infection prevention and control policies and procedures.

These policies and procedures were written in English, and to ensure workplace safety and the effective flow of communication, it was a necessary requirement of all staff undertaking work in quarantine hotels that they understand and speak English well enough to understand and comply with the policies and procedures in place.

113. Over time, it became apparent that many staff, particularly security staff, had language barriers that needed to be addressed by the security companies to ensure safe work practices. It also became apparent that all organisations needed business continuity plans in place to enable quick stand up of alternative staff should staff become unwell and not be able to work, or become COVID-19 positive or close contacts and need to self-isolate. All organisations, like in any workplace during the period, were responsible for ensuring that staff understood they must not come to work, or remain at work, whilst unwell, and that they needed to be tested if they had any COVID-19 symptoms.

You

114. Given the challenges with PPE and other logistics for quarantine hotels in the initial phases, it may have been useful for me to request further logistics support from emergency services organisations to bolster the Department's logistics functions in the State Control Centre, and then the Emergency Operations Centre for hotels, particularly given the speed with which new hotels needed to come on line. I understood many emergency services had been heavily engaged in bushfire response, and resting staff at the time the Program commenced, which may have prevented this support from being available for the length of time needed before dedicated resourcing for the Program could be sourced.

Further information

Question 16: If you wish to include any additional information in your witness statement, please set it out below.

115. The challenges associated with resourcing all aspects of the Hotel Quarantine Program highlight an urgent need for a different approach to planning and readiness of the Victorian Public Service (**VPS**) and executives as surge staff for emergencies. The frequency and diversity of emergencies in Victoria requires the ability to draw on staff from all areas of the VPS, based on a risk assessment approach to guide the simultaneous provision of critical core business and the undertaking of emergency management roles during large scale emergencies.

116. While the State's dedicated emergency management staff, and trained surge staff, would continue to initiate emergency responses, I am of the view that all VPS staff and executives should receive a base level of emergency management induction and training, and

emergency management should be included in all position descriptions, with an expectation of staff support in emergencies as required.

117. The quick appreciation of the potential length of an emergency, and the level of resourcing required, to move emergency operations onto a more sustainable and robust footing is also required in future protracted large scale and complex emergencies, to mitigate risk and protect staff health and wellbeing.

118. Victoria's COVID-19 pandemic experience demonstrates the key decision-making role of governments in national and whole-of-state class 2 emergencies, advised by officers with specific authority under the pertinent legislation, such as Victoria's Chief Health Officer, over a considerable length of time. I acknowledge that large scale and unprecedented emergencies require a high degree of flexibility and adaptability in relation to governance and planning, however the role of Victoria's current emergency management arrangements in these types of emergencies should be reviewed and clarified.

119. It is my view that Victoria's emergency management arrangements are fit for purpose to provide immediate and urgent actions to save lives, protect homes, infrastructure and livelihoods at immediate risk, and undertake relief activities, with agencies operating collectively as per their roles and responsibilities to respond to emergency situations and stabilise communities to begin the recovery process.

120. However, in my view Victoria's emergency management arrangements are not designed to provide protracted operations and program responses to support communities and businesses experiencing significant social and economic effects and consequences over a long period of time. Emergency management agencies must be ready and able to undertake immediate and urgent actions in the next emergency in accordance with a plan, activate, respond, transition/stand down, learn and review, re-set and ready-cycle. Sustainable and dedicated governance and resourcing in longer term, large scale emergencies with significant State-wide consequences is critical, as is the continued interface with emergency management agencies to ensure the current context for the ongoing emergency, in this case COVID-19, informs responses to concurrent emergencies.

Signed at Melbourne

in the State of Victoria

on **9 September 2020**

Andrea Spiteri